## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/08/2013 FORM APPROVED OMB NO. 0938-0391

	OF OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	ONSTRUCTION 00	(X3) DATE COMPL	
ANDTEAN	or connection	IDENTIFICATION NOMBER.	A. BUII B. WIN	LDING G		07/03/2013	
	PROVIDER OR SUPPLIEI	LIVING COMMUNITY		2250 H	ADDRESS, CITY, STATE, ZIP CODE ARVEST MOON DR IAPOLIS, IN 46229		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
R000000	This visit was the Licensure Survey Dates: Facility Number Provider Number AIM Number: It Survey Team: Karina Gates Consus Bed Tom Stauss Rourtney Mujic Tom Stauss Rourtney Rour	For a State Residential vey.  July 1, 2 and 3, 2013  er: 003916  oer: 003916  N/A  Generalist TC  N  c RN  N  ype:	ROO	00000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

State Form Event ID: DF8J11 Facility ID: 003916 If continuation sheet Page 1 of 13

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			B. WING		07/03/2013
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER	8		IARVEST MOON DR	
AUTUMN	GLEN ASSISTED	LIVING COMMUNITY		NAPOLIS, IN 46229	
(X4) ID	STIMMADV S	TATEMENT OF DEFICIENCIES	ID	<u> </u>	(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
R000241	410 IAC 16.2-5-4		1710	· · · · · · · · · · · · · · · · · · ·	DATE
110002-1	Health Services -	. , . ,			
		ration of medications and			
	` '	esidential nursing care shall			
		the resident 's physician			
	-	ervised by a licensed nurse			
		or on call as follows:			
		all be administered by			
		personnel or qualified			
	medication aides.		D.000044		07/04/0040
		view and record	R000241	R241: (Failure to follow Dr.	07/31/2013
		ility failed to ensure the		orders to report weight gain >	
	physician's order for daily weights			lbs.) What corrective actions we be accomplished for those	<u>/III</u>
	was followed for 1 of 5 residents			residents who have been foun	d to
	whose clinical	records were reviewed		been affected by the deficient	
	in the sample of	of 8. Resident #255.		practice? * Henceforth and	•
	,			immediately as of 7/24 nursing	3
	Findings includ	le <sup>.</sup>		will include documentation to	
	i iiiaiiigo iiioiaa			support physician notification i	
	Decident #255	's clinical record was		either progress notes and or in	
				MARs. Complete How will the	
		2/2013 at 2 pm.		facility identify other residents having the potential to be affect	
	_	uded, but were not		by the same deficient practice	
	• •	ertension, COPD		and what corrective action will	
	•	ictive pulmonary		taken? * The facility immediat	
	disease), and e	edema.		audited all resident medical	
				charts for daily weights and	
	An MD order, o	dated 8/29/2012,		parameters. Complete What	•
	indicated, "Dail	ly weight: Call MD for >		measures will be put in place of	
		2 lbs in 24 hour, 5 lbs		what systemic changes will the facility make to ensure that this	
	in 1 week (sho			deficient practice does not rec	
				* Henceforth and going forwa	
	Pacident #255	's May, 2013 MAR		the facility will place all weight	
		•		orders in a confidential QA	
	•	ministration record)		Nursing Communication Binde	er
		ollowing daily weights:		available only to licensed	
		3.4 and on the 5th:		personnel. All licensed nursing	•
	196.2			personnel will be required to re	ead,
	-on the 7th: 19	6.4, on the 8th: 199.8,		and initial the daily log before	

State Form Event ID: DF8J11 Facility ID: 003916 If continuation sheet Page 2 of 13

STATEMEN	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2			ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	LDING	00	COMPLETED	
				LDING		07/03/2013	
			B. WIN		ADDRESS CITY STATE ZIR CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADVEST MOON DD		
A 1 1 <del>T</del> 1 18 48	LOLEN ACCIOTED	LIVIANO CONMANDATIVA			ARVEST MOON DR		
AUTUM	I GLEN ASSISTED	LIVING COMMUNITY		INDIAN	APOLIS, IN 46229		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	on the 9th: 201	1.8, on the 10th: 189.9			assuming shift responsibilities.		
	and on the 11t	h: 195.2			Initials will verify responsibility	for	
	-on 20th: 193.	on the 21st: 196, on			<u>all</u> previous prior physician		
		8, on the 23rd: 196, on			orders. * The July 25th In-		
		on the 25th: 194.6, on			service will be used to implemand brief all licensed personne		
					on the systemic changes to	51	
		on the 27th: 194.6, on			communicating physician orde	ers	
	ine 28th: 201.2	2 and on the 29th: 198.			as well as re-briefing record	-	
					documentation to support		
	Review of Res	ident #255's clinical			physician notification in either		
	record indicate	ed documentation of			progress notes and or in MAR		
	notifying the M	D of the above weight			Complete NLT 7/25/ 13How w	<u>ill_</u>	
	changes could not be found.				the corrective actions be		
					monitored to ensure the deficie		
	An interview w	ith the Director of			practice will not recur, i.e. wha quality assurance program will		
		/2013 at 1:06 pm			put into place? * The DON or		
	I —	·			charge nurse will review the Q		
		ID was not notified of			Nurse Communication Binder		
		nges in May each day			daily for shift compliance and		
		nt change of greater			signify with an initial on each		
	than 2 lbs. She	e indicated the MD			page. Any licensed nursing		
	comes in at lea	ast twice a month and			associate missing a signature		
	reviews the clir	nical records. She			be immediately notified to retu		
	indicated staff	at the facility primarily			and review the information. *	An	
		with the MD through			"End of Month Audit", will be	NI.	
		ited she did not have			conducted monthly by the DOI and or Charge Nurse and sign		
					off for the QA Nursing	cu	
	1	ation of faxes in May			Communication Binder and cre	oss	
	relating to weld	ght fluctuations.			checked with the medical char		
		N			as applicable, for compliance	with	
	, ,	Visit List for Next			weight reporting and other		
		utumn Glen Assisted			relevant provisions of care as		
	Living" sheet, p	provided by the Director			may be listed in the confidentia	al	
	of Nursing on 7	7/3/2013 at 1:50 pm,			QA Nursing Communications		
	indicated, "Sch	neduled Date of Visit:			Binder. Results of this audit wi be recorded and placed behind		
	· ·	me of Resident #255)			the last day of the month's pag		
	,	ymbol for arrow down			*The QA requirement to condu	-	
		•			a monthly audit will be added to		
	(lower) extrem	itys [sic](legs) Bilat.			and the second s		

State Form Event ID: DF8J11 Facility ID: 003916 If continuation sheet Page 3 of 13

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			A. BUILDING B. WING		07/03/2013
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER	₹			
A LITLINAN	I OI ENI ACCIOTED	LIVING COMMUNITY		HARVEST MOON DR NAPOLIS, IN 46229	
AUTOMIN	GLEN ASSISTED	LIVING COMMONT F	INDIAI	NAPOLIS, IN 40229	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	(bilateral or bot	th), swollen."		and cross checked with the	
	•	•		Monthly Nursing QA checklist	
	An interview w	ith the Director of		be completed NLT 7/31/13. E	<u>By</u>
		/2013 at 1:52 pm		what date will the systemic	
	_	·		changes be completed? * All	
		did not have any further		actions have either been	d
		of staff follow-up on		completed and or implemente with the exception of finalizing	
	•	lent #255's daily		new Monthly QA Checklist wh	
	weights were g	reater than 2 lbs		will be completed NLT 7/31/13	
	change in 24 h	ours during May 2013.		Thus, all actions will have bee	
	]	2		completed NLT 7/31/13.	
				Reason For IDR * We have	a
				letter from his physician statin	g
				that we did call in the weight	
				changes.	
				Autumn Glen Assisted Living,	
				provider number 003916, is	
				requesting an Independent Review	
				face to face of R241 Health Services	5
				–Offense	
				At issue here, and the evidence use	d
				to cite, is whether we followed	
				doctor's orders and reported weigh	t
				gains greater than 2 pounds for	
				resident #255. We assert our staff	
				did and can prove it using a letter	
				from his physician, which we were	
				unable to produce as this matter	
				came up approximately one hour	
				prior to the announced out-brief	
				time on July 3rd.	
				The administration of modications	
				The administration of medications and the provision of residential	
				nursing care shall be as ordered by	
				the resident's physician and shall be	
				supervised by a licensed nurse on	<u>-</u>
				the premises or on call as follows:	
				are premises of off call as follows.	
				As we stated to the surveyor's our	

State Form Event ID: DF8J11 Facility ID: 003916 If continuation sheet Page 4 of 13

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE SURVEY COMPLETED 07/03/2013		
	ROVIDER OR SUPPLIER	LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE  2250 HARVEST MOON DR  INDIANAPOLIS, IN 46229				
(X4) ID PREFIX	SUMMARY S	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI	E COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	nursing staff did it verbally usuall by phone and rarely by fax but always as required. In a letter fro	DATE y		
				the resident's physician (See attachment B, Letter from reside 255's physician) stating that we d maintain constant contact with h	id		
				reporting weight changes as required. Thus we were in compliance and do not see where			
				we violated this rule.  That (1) Medication shall be administered by licensed nursing			
				personnel or qualified medication aides. Medication aides (seems to have no relevancy here).			
				We also take exception to the lab this tag brings as an "offense". 4 IAC 16.2-5-1.1 defines an offense	10		
				followsAn offense presents a substantial probability that death a life threatening condition will result. There was never a substan	tial		
				probability of death nor did, as the word "will" supposes, a life threatening condition result because we called the doctor with his			
				weights and his health has been under the care and scrutiny of his physician. Resident 255 is as			
				baseline healthy today as he was then.  Thus we are requesting a face to			
				face hearing to put forward our contention that no offense has occurred and that R241 is not a			
				proper or fair tag and should be			

State Form Event ID: DF8J11 Facility ID: 003916 If continuation sheet Page 5 of 13

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING B. WING	00	COMPLETED 07/03/2013
	ROVIDER OR SUPPLIER GLEN ASSISTED	LIVING COMMUNITY	2250 H	ADDRESS, CITY, STATE, ZIP CODE ARVEST MOON DR IAPOLIS, IN 46229	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	removed from our record. Thanly you for your time and attention. Please tell me where I can send mail the attachments.  Sincerely, Thomas J. Knapik, Administrator, Autumn Glen Assisted Living  2250 Harvest Moon Dr. Indianar IN 46229  (317) 891-1508 or Admin@AutumnglenALF.com	or e

State Form Event ID: DF8J11 Facility ID: 003916 If continuation sheet Page 6 of 13

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITH DING	00	COMPLETED
			A. BUILDING B. WING		07/03/2013
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER				
A LITLIMAN	I CI EN ACCIOTED	LIVING COMMUNITY		IARVEST MOON DR NAPOLIS, IN 46229	
AUTUMN	I GLEN ASSISTED	LIVING COMMUNITY	INDIAN	NAPOLIS, IN 46229	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
R000406	410 IAC 16.2-5-1	• •			
	Infection Control -				
	· '	ust establish and maintain			
		ol practice designed to			
	-	anitary, and comfortable to help prevent the			
		transmission of diseases			
	and infection.	transmission of discusses			
		rvation, interview, and	R000406	R406: (Infection Control) WI	hat 07/31/2013
		the facility failed to		corrective actions will be	0,7,51,2015
		ect a blood glucose		accomplished for those reside	ents_
		e between resident		who have been found to been	
	_			affected by the deficient practi	ice?
		the potential to affect 4		* Immediately switched from	
		who received daily		manufacturer's (ARKRAY) blo	
	_	testing on the 100/400		glucose recommended Option to recommended Option 2	11
	halls (#300, 50	, 616, and 199).		(bleach) for cleaning and	
				disinfecting the blood glucose	
	Findings includ	le:		meters on 7/3/13. (See	
	_			Attachment 1. Completed	
	During a rando	m observation of blood		7/3/13). However upon arrival	<u>of</u>
	_	, on 7/2/13 at 11:44		new stronger chemicals and	
		dent #50, LPN #1		based on a recommendation f	
	•	lood glucose testing		the Manufacturer we are now	-
	-	_		using Super Sani Cloth Germicidal disposable Wipes	
		lcohol wipes; no		which is again Option	•
	•	olution were used to		1. Complete 7/3/13 * Immedia	ately
		nine at that time.		in-serviced LPN#1 on ARKRA	-
	•	view with LPN #1, at		recommended procedure to c	lean
	the same time,	LPN #1 indicated the		and disinfect the Assure Platir	num
	blood glucose t	testing machine was		blood glucose monitoring met	
	shared betwee	n residents on the		Completed 7/3/13 * Immedia	ately
	100/400 hall.			requested individual blood	s all
				glucose meters be provided to diabetic residents as	) <u>all</u>
	At 11:52 a m	on 7/2/13, LPN #1		recommended by the CDC.	
		t #50's room after the		However, upon further review	and
				based on a CLIA	
	_	test and placed the		recommendation, each med c	art_
	blood glucose t	testing machine in the		will be equipped with 2 meters	<u>s</u>

State Form Event ID: DF8J11 Facility ID: 003916 If continuation sheet Page 7 of 13

STATEMEN	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIII	DDIG	00	COMPLE	ETED
				LDING		07/03/2	2013
			B. WIN		ADDRESS OVEN STATE JID CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
		1 1) (I) (A) (A) (A) (A) (A) (A) (A) (A) (A) (A			ARVEST MOON DR		
AUTUMN	I GLEN ASSISTED	LIVING COMMUNITY		INDIAN	APOLIS, IN 46229		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	100/400 medic	cation (med) cart,			and residents will not individua		
	without wiping	off the blood glucose			possess their own meters as t	he_	
	testing machin	•			manufacturer and CLIA		
		<b>.</b>			understand the problems of		
	On 7/2/12 of 1	12:06 n m   I DN #1			correctly calibrating so many	-6.4	
		2:06 p.m., LPN #1			meters. Thus due to a risk ber analysis it is felt that this syste		
	•	blood glucose testing			will besuperior. Complete *	<u> </u>	
		the med cart and wiped			Immediately reviewed all diabe	<sub>etic</sub>	
	the blood gluce	ose testing machine			resident files for possible		
	with alcohol wi	pes; no bleach			infectious diseases such as HI	V,	
	wipes/solution	were used to			Hepatitis B and C and C-diff,		
	disinfect/clean	the blood glucose			finding none. Complete *		
	testing machine at that time. LPN #1 then went into the dining room to				Immediately inserted into the 2	24	
					hour Com log Report Binder		
		t #616 back to her			ARKRAY recommended		
					procedures on how to clean ar	nd	
		od glucose test.			disinfect the blood glucose		
		indicated she wanted			monitoring meters for review.  Complete * Immediately		
	to wait until aft	er lunch to have the			Ordered and received addition	al I	
	test administer	red, so LPN #1 then			germicidal back-up wipes with		
	placed the bloc	od glucose testing			bleach and without as		
	machine back	into the 100/400 med			recommended by the ARKRA	Y	
		ne same time, LPN #1			representative so as not to rur	ı	
	_	g an interview, she			out. Complete * Contacted		
		•			pharmacy and ARKRAY		
	1	ood glucose testing			Manufacturer's Representative	es	
		cleaned with bleach			for best practice		
		nift and should be			recommendations which were	<sub>th</sub>	
	disinfected with	h bleach wipes/solution			presented in a special July 25 in-service on disinfecting and	uı	
	between each	resident use.			cleaning the ARKRAY unit.		
					Completed 7/25/13 How will t	<sub>he</sub>	
	At 1:13 p.m o	n 7/2/13, LPN #1 was			facility identify other residents		
	-	ing down the hall			having the potential to be affect	- 1	
		00/400 med cart with			by the same deficient practice		
					and what corrective action will	<u>be</u>	
	· `	d) non-professional,			taken? * The facility has		
	bleach-free wip	Des.			identified all diabetic residents		
					using a shared blood glucose		
	During an inter	view with LPN #1, on			meter and reviewed their reco	ras	

State Form Event ID: DF8J11 Facility ID: 003916 If continuation sheet Page 8 of 13

STATEMEN	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPL	ETED
			A. BUII			07/03/2013	
			B. WIN		ADDRESS CITY STATE ZIR CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
A 1 1 <del>T</del> 1 18 48	LOLEN ACCIOTED	LINVINIO COMMANIANITY			ARVEST MOON DR		
AUTUM	I GLEN ASSISTED	LIVING COMMUNITY		INDIAN	APOLIS, IN 46229		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	7/2/13 at 1:15	p.m., she indicated she			for symptoms of infectious block		
	always used a	lcohol wipes to clean			borne pathogens, finding none		
	the blood gluce				In addition we have implement	ted	
	1	was just given (name			all actions listed above for all		
		s to disinfect the blood			diabetic residents. Complete		
					What measures will be put in place or what systemic change	-	
	_	g machine between			will the facility make to ensure		
	resident use.				that this deficient practice does		
					not recur? * We will add QA	_	
	On 7/2/13, at 1	l:17 p.m., LPN #1 was			monitoring of cleaning and		
	observed clear	ning the blood glucose			disinfecting of blood glucose		
	testing machin	e with the (name of			meters to the specific checklis		
		ofessional, bleach-free			Monthly Nursing QA checklist.		
		1 then performed			Complete by 7/31/13 * Order		
		's blood glucose test.			new and stronger chemicals a		
		•			specifically recommended by t units's manufacturer to disinfe		
		xited Resident #616's			and clean a larger group of	Cl	
		ned the blood glucose			pathogens as recommended b	<b>N</b> /	
	testing machin	e with the (name of			the CDC. * In-serviced all	, y	
	brand) non-pro	fessional, bleach-free			nursing personnel as to specifi	ic	
	wipes.				procedures using specific		
					chemicals as recommended by	y	
	At 3:00 p.m., o	n 7/2/13, the DoN			the CDC and the manufacture		
	•	rsing) indicated the			<ul> <li>* Increased training and future</li> </ul>	9	
	,	as for staff to follow the			training through specific	_	
					in-services with insertion of ye		
		s policy for disinfecting			in-servicing of all licensed nurs	sing	
	_	ose testing machine.			personnel regarding recommended procedure for		
		ated the facility had			cleaning and disinfecting gluce	ose	
	_	e (name of brand)			monitoring meters beginning w		
	non-profession	nal, bleach-free wipes			the 6/25/13 in-service and year		
	for about a mo	nth, when the facility			thereafter. How will the	•	
	changed pharr	-			corrective actions be monitore		
	555,611				ensure the deficient practice w	<u>/ill</u>	
	During a recor	d review of a policy (no			not recur, i.e. what quality		
	_	• • •			assurance program will be put		
	, ,	e of brand) blood			into place? * The Nursing QA		
		machine, received			Checklist for licensed nursing		
	from the Admir	nistrator on 7/2/13 at			contain an added check off ite	111	

State Form Event ID: DF8J11 Facility ID: 003916 If continuation sheet Page 9 of 13

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			B. WING		07/03/2013
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER			ARVEST MOON DR	
ALITIIMA	I CI EN ASSISTED	LIVING COMMUNITY		IAPOLIS, IN 46229	
AUTUMIN	GLEN ASSISTED	LIVING COMMONT I	INDIAN	IAF OLIS, IN 40229	
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	3:05 p.m., it in	dicated, "to disinfect		for spot checks of nursing	
	the meter, dilut	e 1 mL (milliliter) of		compliance with recommende	
	· ·	ach (5-6% sodium		procedures as provided by the	
		plution) in 9 mL of		manufacturer's literature. By v	
		•		date will the systemic changes	
		a 1:10 dilution. The		completed? All systemic change that have not been completed.	
		tion is 0.5-0.6%		that have not been completed immediately will be completed	
	sodium hypoch	ılorite."		NLT 7/31/13 Reason For IDF	
				Autumn Glen Assisted Living,	`.
	A review of the	MSDS (Material		provider number 003916, is	
		neet) for (name of		requesting an Independent	
	brand) disinfecting, non-professional			Review face to face for R406	
	, , ,			Infection Control- Offense Hea	alth
	wipes, received from the			Services -Offense The state h	nas
	Administrator, on 7/2/13 at 3:05 p.m.,			tagged us with an infection	
	did not indicate	e a 0.5-0.6% sodium		control offense because they	
	hypochlorite in	gredient/solution, for		contend the facility did not	
	the wipe.			properly disinfect a blood gluc	
	-			machine between resident use	e. It
	On 7/3/13 at 10	0:35 a.m. the		is our contention that LPN #1	
		ndicated the facility		removed an already cleaned, Blood Glucose meter from the	
		sinfectant wipes the		cart as they are cleaned with	
		· •		bleach between shifts and aga	ain
	•	ng that contained the		wiped it down with only alcoho	<b>I</b>
	above bleach s	solution/ingredient.		as it was clean, and used it to	
				Resident #50. LPN #1 states	
	A list, titled Acc	cuchecks, received		finding no wipes on the cart sh	ne
	from the DoN of	on 7/2/13 at 10:36 a.m.,		set it down on a paper towel o	n
		idents received daily		the cart so as not to cross	
		testing, on the 100/400		contaminate the cart. Before	
	hall.			testing her next resident, she	
	i iaii.			would again wipe it down with	
		0.40		alcohol and then clean it with	200
	On 7/3/13, at 1			wipes provided to her. The wip provided her were Clorox	ا ا
	Administrator in	ndicated the facility		Disinfecting Wipes (without	
	was using a ble	each solution to		bleach); however as Clorox	
	disinfect the blo	ood glucose testing		states, Clorox Disinfecting Wig	pes
		ously, but they ran out		are a commercially available,	
	•	a couple of days ago,		EPA-registered disinfectant wi	ipe
		a couple of days ago,			

State Form Event ID: DF8J11 Facility ID: 003916 If continuation sheet Page 10 of 13

TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  SO SOMEONE WENT OUT to buy the non-professional, bleach-free wipes.  So someone went out to buy the non-professional, bleach-free wipes.  TAG Someone went out to buy the non-professional, bleach-free wipes.  TAG Someone went out to buy the non-professional, bleach-free wipes.  TAG Someone went out to buy the non-professional, bleach-free wipes.  TAG Someone went out to buy the non-professional, bleach-free wipes.  TAG SOMEONE THE APPROPRIATE DETECTION.  TAG SOMEONE THE APPROPRIATE DETECTION.  THE APPROPRIATE DETECTION.  THE APPROPRIATE DETECTION.  THE APPROPRIATE DETECTION.  TO HAT Considered to kill 99.9% of all germs. (See Attachment D from the Clorox Company) And we submit that Option 1 from the manufacturer's, (ARKRAY) handout How to Clean and Disinfect Your Blood Glucose Meter, (see attachment 1) where the manufacturer states"Option 1 Cleaning and disinfecting can be completed using a commercially available EPA-registered disinfectant detergent or germicide wipe",	STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
NAME OF PROVIDER OR SUPPLIER AUTUMN GLEN ASSISTED LIVING COMMUNITY  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  so someone went out to buy the non-professional, bleach-free wipes.    Someone went out to buy the non-professional   Deficiency wipes	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUJLDING	00	COMPLETED
NAME OF PROVIDER OR SUPPLIER  AUTUMN GLEN ASSISTED LIVING COMMUNITY  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  SO someone went out to buy the non-professional, bleach-free wipes.  SO someone went out to buy the non-professional, bleach-free wipes.  SO someone went out to from the Clorox Company) And we submit that Option 1 from the manufacturer's, (ARKRAY) handout How to Clean and Disinfect Your Blood Glucose Meter, (see attachment 1) where the manufacturer states"Option 1 Cleaning and disinfecting can be completed using a commercially available EPA-registered disinfectant detergent or germicide wipe",						07/03/2013
AUTUMN GLEN ASSISTED LIVING COMMUNITY  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  So someone went out to buy the non-professional, bleach-free wipes.  So someone went out to buy the non-professional, bleach-free wipes.  So someone went out to buy the non-professional (ARKRAY) handout How to Clean and Disinfect Your Blood Glucose Meter, (see attachment 1) where the manufacturer states"Option 1 Cleaning and disinfecting can be completed using a commercially available EPA-registered disinfectant detergent or germicide wipe",			<u> </u>		ADDRESS, CITY, STATE, ZIP CODE	1
AUTUMN GLEN ASSISTED LIVING COMMUNITY  (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG SO SOMEONE WENT OUT to buy the non-professional, bleach-free wipes.  ID PREFIX TAG SO SOMEONE WENT OUT TO BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  SO SOMEONE WENT OUT to buy the non-professional, bleach-free wipes.  ID PREFIX TAG PREFIX TAG  PREFIX TAG  PREFIX TAG  PREFIX TAG  TAG  PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE  THAT CONTAINS A detergent. It is germicidal and considered to kill 99.9% of all germs. (See Attachment D from the Clorox Company) And we submit that Option 1 from the manufacturer's, (ARKRAY) handout How to Clean and Disinfect Your Blood Glucose Meter, (see attachment 1) where the manufacturer states"Option 1 Cleaning and disinfecting can be completed using a commercially available EPA-registered disinfectant detergent or germicide wipe",	NAME OF P	PROVIDER OR SUPPLIEF	8			
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  So someone went out to buy the non-professional, bleach-free wipes.  So someone went out to buy the non-professional, bleach-free wipes.  So someone went out to buy the non-professional, bleach-free wipes.  TAG  ### COMPLETIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE  ### DATE  COMPLETIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE  ### DATE  COMPLETIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE  ### DATE  COMPLETIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE  ### DATE  COMPLETIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE  ### DATE  COMPLETIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE  ### DATE  COMPLETIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE  ### DATE  ### DATE  COMPLETIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE  ### DATE  ### DATE  COMPLETIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE  ### DATE  ### DATE  COMPLETIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE  ### DATE  ### DATE  COMPLETIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE  ### DATE  ### DATE  COMPLETIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE  ### DATE  ### DATE  ### DATE  COMPLETIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE  ### DATE  ### DATE  COMPLETIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE  ### DATE  COMPLETIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE  ### DATE  ### DATE  COMPLETIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE  ### DATE  ### DATE  COMPLETIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE  ### DATE  COMPLETIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE  ### DATE  COMPLETIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE  ### DATE  COMPLETIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE  ### DATE  COMPLETIVE DATE  COMPLETIVE DATE  COM		I GLEN ASSISTED	LIVING COMMUNITY			
TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  So someone went out to buy the non-professional, bleach-free wipes.  TAG that contains a detergent. It is germicidal and considered to kill 99.9% of all germs. (See Attachment D from the Clorox Company) And we submit that Option 1 from the manufacturer's, (ARKRAY) handout How to Clean and Disinfect Your Blood Glucose Meter, (see attachment 1) where the manufacturer states"Option 1 Cleaning and disinfecting can be completed using a commercially available EPA-registered disinfectant detergent or the APPROPRIATE DATE  CROSS-REFERENCED TO THE APPROPRIATE DETECTION.  TAG CROSS-REFERENCED TO THE APPROPRIATE DETECTION.  TAG CROSS-REFERENCED TO THE APPROPRIATE DETECTION.  TAG CROSS-REFERENCED TO THE APPROPRIATE DETECTION.  That contains a detergent. It is germicidal and considered to kill 99.9% of all germs. (See Attachment D from the Clorox Company) And we submit that Option 1 from the manufacturer's, (ARKRAY) handout How to Clean and Disinfect Your Blood Glucose Meter, (see attachment 1) where the manufacturer states"Option 1 Cleaning and disinfecting can be completed using a commercially available EPA-registered disinfectant detergent or germicide wipe",					PROVIDER'S PLAN OF CORRECTION	` ´
so someone went out to buy the non-professional, bleach-free wipes.  that contains a detergent. It is germicidal and considered to kill 99.9% of all germs. (See Attachment D from the Clorox Company) And we submit that Option 1 from the manufacturer's, (ARKRAY) handout How to Clean and Disinfect Your Blood Glucose Meter, (see attachment 1) where the manufacturer states"Option 1 Cleaning and disinfecting can be completed using a commercially available EPA-registered disinfectant detergent or germicide wipe",		`			CROSS-REFERENCED TO THE APPROPRIA	
non-professional, bleach-free wipes.  germicidal and considered to kill 99.9% of all germs. (See Attachment D from the Clorox Company) And we submit that Option 1 from the manufacturer's, (ARKRAY) handout How to Clean and Disinfect Your Blood Glucose Meter, (see attachment 1) where the manufacturer states"Option 1 Cleaning and disinfecting can be completed using a commercially available EPA-registered disinfectant detergent or germicide wipe",	TAG		*	TAG	,	
from the manufacturer, also describes Clorox Disinfecting Wipes which they state contains a disinfectant germicide and a detergent in the product. Thus we feel we were compliant. Note Option 2 uses a 1:10 concentration of bleach, which again, is optional. Even the CDC handout titled "Infection Prevention during Blood Glucose Monitoring and Insulin Administration" (See attachment 2, page 3 of 8) is only a recommendation. Under Best Practices for Assisted Blood Glucose Monitoring and Insulin Administration the word "recommendation" is carefully used in the first sentence of the first two paragraphs. The CDC uses the word "recommendation" not by accident, but picking their words carefully and	TAG	so someone w	ent out to buy the		that contains a detergent. It is germicidal and considered to 199.9% of all germs. (See Attachment D from the Clorox Company) And we submit that Option 1 from the manufacture (ARKRAY) handout How to Cl and Disinfect Your Blood Gluc Meter, (see attachment 1) whe the manufacturer states"Op 1 Cleaning and disinfecting case be completed using a commercially available EPA-registered disinfectant detergent or germicide wipe", which we submit with evidence from the manufacturer, also describes Clorox Disinfecting Wipes which they state contain disinfectant germicide and a detergent in the product. Thus feel we were compliant. Note Option 2 uses a 1:10 concentration of bleach, which again, is optional. Even the Chandout titled "Infection Prevention during Blood Gluco Monitoring and Insulin Administration" (See attachmed 2, page 3 of 8) is only a recommendation. Under Best Practices for Assisted Blood Glucose Monitoring and Insulin Administration the word "recommendation" is carefully used in the first sentence of the first two paragraphs. The CDC uses the word "recommendation to by accident, but picking the	kill  at er's, lean cose ere tion an er er ent er
understanding the difference between a recommended and a						а

State Form Event ID: DF8J11 Facility ID: 003916 If continuation sheet Page 11 of 13

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	00	(X3) DATE SURVEY COMPLETED 07/03/2013		
	ROVIDER OR SUPPLIEF	LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE  2250 HARVEST MOON DR INDIANAPOLIS, IN 46229				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
				mandatory procedure. "Best practices" can and do change Alcohol used to be the disinfectant of choice not just common antiseptic. Only a fe short years ago bleach itself forbidden in facilities by the sor so we were told and thus assumed many of us assume to be mandatorily forbidden. any case best practices evolutinate and sometimes differ assert that we did indeed have compliant practice but maybe the "best practice" as interpreby the ISDH. (See Attachmonage 6 of 8, titled "Recommended Practice for preventing Blood borne Path Transmission during Blood Glucose Monitoring and Insu Administration in Healthcare Settings") Again notice the we "recommended". The reason bring this up is to add further evidence that we are being tagged based upon a recommended procedure, should not and probably is not mand by either he State of Indiana, CDC, or even ARKRAY the manufacturer. However, pleanote these recommendations have been immediately adop as any intelligent provider word owhen shown a better pracand for that we are thankful to survey team for pointing out the were not using optimal chemical disinfectant. Thus, labeling our practice as an offense seems arbitrary. In	was tate,  ed it In /e, . We /e a e not eted ent 2,  ogen  lin  ord I  ould lated the  ase ited uild tice o our that		

State Form Event ID: DF8J11 Facility ID: 003916 If continuation sheet Page 12 of 13

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/08/2013 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER:	A. BUILDING B. WING	00 	COMPLETED 07/03/2013
	ROVIDER OR SUPPLIER	LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE  2250 HARVEST MOON DR  INDIANAPOLIS, IN 46229		
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC	EATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  Residential Care Rule 5, 410 l 16.2-5-1.1 an offense is define as follows(1) An offense presents a <u>substantial</u> <u>probability</u> that <u>death</u> or a <u>life</u> threatening condition <u>will</u> res Notice it did not say might res It used the word will. If such w the case, then why would our procedure not be stopped immediately to save a life? I believe the answer is that ther	DATE  AC ed  Lac l
				was not a substantial probabil that death or a life threatening condition would (will) occur an without substantial probability death or certainty of a life threatening condition, R406, in have been incorrectly applied. Without the benefit of using defined regulation on "best practices", how can there be consistency as applied betwee facilities? Thus we are reques a face to face hearing to put forward and defend our contention that no "offense" had occurred. Thank you for your fand attention. Sincerely, Thor J. Knapik, Administrator, Autu Glen Assisted Living 2250 Harvest Moon Dr. Indianapolis 46229 (317) 891-1508 or Admin@AutumnglenALF.com	en ting as time mas mn

State Form Event ID: DF8J11 Facility ID: 003916 If continuation sheet Page 13 of 13